United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 18-0235**
	)	**Issued: September 10, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Warwick, RI, Employer	)	

Appearances:
David P. McCormack, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge

JURISDICTION

On November 13, 2017 appellant, through counsel, filed a timely appeal from a May 16, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id*.; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] Together with his appeal to the Board, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). By order dated August 9, 2018, the Board exercised its discretion and denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 18-0235 (issued August 9, 2018).

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 31 percent permanent impairment of the left lower extremity, for which he previously received a schedule award.

FACTUAL HISTORY

On October 13, 2004 appellant, then a 50-year-old letter carrier, filed traumatic injury claim (Form CA-1) alleging that he sustained an injury as a result of twisting his left knee causing a pop while in the performance of duty. OWCP initially accepted the claim for synovitis/sprain of the left knee and authorized a January 25, 2005 left knee surgery. Appellant underwent an authorized total left knee arthroplasty on September 20, 2010. He subsequently returned to full-time modified-duty work on April 25, 2011 based on a second opinion examination dated March 23, 2011 by Dr. Medhat A. Kader, a Board-certified orthopedic surgeon, who opined that he was capable of sedentary work with restrictions. Appellant returned to full-duty work on July 12, 2011.

In an October 27, 2011 report, Dr. Robert M. Shalvoy, a Board-certified orthopedic surgeon, indicated that appellant presented for a one year reevaluation of his left total knee arthroplasty. Dr. Shalvoy noted that appellant had soreness and swelling at the end of the day and complained of soft tissue clicking in the suprapatellar pouch. Upon physical examination he found some residual soft tissue swelling in the left knee compared to the right, and some residual quad atrophy. Range of motion (ROM) testing showed some crepitus in the suprapatellar pouch, but no tenderness to palpation. ROM was 0 to 130 degrees of flexion without laxity or instability in the left knee. Appellant's calves were soft bilaterally and motor, sensory, and reflex function were symmetrically intact. Dr. Shalvoy found good pulses and capillary refill in both feet. He reviewed an x-ray taken that day and found no evidence of settling, loosening, or fracture in the left knee. Dr. Shalvoy opined that appellant had reached maximum medical improvement (MMI) one year after surgery and was capable of performing regular duty. He concluded his report indicating that appellant had 37 percent permanent impairment of the left lower extremity.

In an April 30, 2013 report, Dr. Shalvoy noted that appellant had significant swelling and stiffness by the end of his workday walking his route, which was aggravated by walking stairs. Appellant's ROM had diminished to 105 degrees and Dr. Shalvoy explained that this was associated with his swelling. He opined that appellant's condition was consistent with a class 3 diagnosis with mild motion deficit as per Table 16-23, page 539, of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4] Dr. Shalvoy concluded that there was no additional modifier.

In an August 23, 2013 report, Dr. Byron V. Hartunian, a Board-certified orthopedic surgeon, diagnosed status post left total knee replacement for end-stage degenerative arthritis of the left knee, anterior and medial synovitis of the left knee, and sprain of the left knee. Dr. Hartunian conducted a physical examination and found that appellant could sit and stand

[4] A.M.A., *Guides* (6th ed. 2009).

independently and ambulate in a normal heel/toe manner without a noticeable limp. While standing, there was a three-degree valgus alignment through the left knee and a three-degree varus alignment through the right knee. Appellant was able to squat 50 percent of normal, restricted by limited mobility of his left knee and anteromedial discomfort. Regional examination of the left knee indicated a well-healed anterior longitudinal scar, not stretched, discolored, or elevated. There was visible swelling about the left knee, palpable effusion, and a three-quarter of an inch measurable swelling circumferentially at the midpoint of the patella of the left knee compared to the right side. The ROM of the left knee, measured with a goniometer and performed three times with the highest range recorded, was flexion of 106 degrees and extension zero degrees. This compared to 135 degrees of flexion on the right with zero degree of extension. There was moderate tenderness to palpation of the patellofemoral joint and anterior medial joint line. There was no ligament laxity on stressing the knee. Examination of the left hip, ankle, and foot demonstrated no tenderness at those joints, full ROM, no ligament laxity of the ankle or foot, and normal neurovascular examination of the left lower extremity. Dr. Hartunian determined that appellant had reached MMI on October 27, 2011, one year after undergoing the left total knee replacement surgery performed by Dr. Shalvoy.

Dr. Hartunian provided an opinion of the extent of appellant's permanent impairment. Utilizing Table 16-3,[5] *Knee Regional Grid*, of the A.M.A., *Guides*, he opined that appellant's condition was consistent with a class 3 diagnosis for the diagnosis of total knee replacement because the physical examination indicated a mild motion deficit per Table 16-25.[6] Dr. Hartunian did not assign a grade modifier for clinical studies (GMCS) because x-rays at the one-year follow-up confirmed the diagnosis. He assigned a grade modifier of 2 for physical examination (GMPE) because moderate palpatory findings were consistently documented and supported by the observed abnormalities. Dr. Hartunian assigned a grade modifier of zero for functional history (GMFH) because there was no antalgic limp. Appellant completed an American Academy of Orthopedic Surgeons (AAOS) lower limb questionnaire[7] and Dr. Hartunian found that appellant's answers warranted a grade modifier of 3 for severe deficit. Dr. Hartunian noted that the A.M.A., *Guides* "indicate that the higher grade modifier 3 is to be used in the calculation." Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), he calculated that appellant had a net adjustment of (0-3) + (3-3) + (n/a) = -1, equaling a class 3, grade B impairment. Based on these calculations, Dr. Hartunian concluded that appellant had 34 percent permanent impairment of the left lower extremity.

On August 29, 2013 appellant filed a claim for a schedule award (Form CA-7).

[5] *Id*. at 549.

[6] *Id*. at 550.

[7] The A.M.A., *Guides* explain on page 516 that inventories must be widely accepted and have documented reliability and validity. The AAOS lower limb instrument is one inventory that may be used. Information and scoring is provided at the AAOS website. An inventory is used only to assist the examiner in defining the grade for functional history and does not serve as a basis for defining further impairment nor does the score reflect an impairment percentage (see Table 16-6).

By decision dated January 17, 2014, OWCP expanded appellant's claim and accepted medial meniscus tear of the left knee and post-traumatic arthritis of the left knee.

On March 26, 2014 Dr. Morley Slutsky, a Board-certified occupational medicine specialist serving as a district medical adviser (DMA), reviewed the medical evidence of record and determined that appellant's date of MMI was October 27, 2011, one year after she had her left total knee replacement surgery performed by Dr. Shalvoy. He concurred with Dr. Hartunian that appellant's most impairing diagnosis was total knee replacement with mild motion deficit, which was a class 3 diagnosis. The DMA disagreed with Dr. Hartunian's impairment rating, which had indicated that appellant's AAOS score was consistent with a GMFH of 3. He explained that the AAOS score was unreliable and used only as an "adjuvant," not the main determinate of the GMFH. The DMA explained that there was no documentation of a positive Trendelenburg and appellant did not have an antalgic gait, nor did he require the use of a single gait aid or external orthotic device for stabilization. He opined that this was consistent with appellant's ability to function per Table 16-6's criteria[8] and, as such, appellant's GMFH was 1 for his finding of only a mild problem. The DMA concurred with Dr. Hartunian's GMPE of 2 due to tenderness to palpation/crepitation and swelling and that a GMCS was not applicable in this case. Using the net adjustment formula (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX), he calculated that appellant had a net adjustment of (1-3) + (2-3) + (n/a) = -2, equaling a class 3, grade A impairment. Based on these calculations, the DMA concluded that appellant had 31 percent permanent impairment of the left lower extremity.

Dr. Hartunian was provided a copy of the DMA's report for his review and comment. In a June 4, 2014 letter, he noted that the only conflict in medical opinion was in relationship to the GMFH for the left knee. Dr. Hartunian explained that he disagreed with the DMA and explained that he had used Table 16-5 on page 515 of the A.M.A., *Guides* to determine his grade modifiers by using the highest class modifier as the value for each adjustment in the net adjustment calculation. He further indicated that he did not understand why the DMA had found the AAOS score to be unreliable. Dr. Hartunian noted that the "[A.M.A.,] *Guides* provides that, 'If any of these factors [within Table 16-5] are determined by the examiner to be unreliable or inconsistent they should be excluded in the grading adjustment. I found no basis for so concluding.'" He emphasized that, as suggested by the A.M.A., *Guides* that he was the examining physician and had an opportunity to interact with his patient significantly during the examination and found him sincere and honest, and thus the AAOS questioner was likely valid. Dr. Hartunian reiterated his opinion that appellant's GMFH was 3. He further explained his belief that the DMA had misconstrued the exclusion provision for GMFH in this case and that there was no support for the finding of a GMFH of 1 in the record or within the A.M.A., *Guides*.

By decision dated September 5, 2014, OWCP granted appellant a schedule award for 31 percent permanent impairment of the left lower extremity. It noted that it had relied on the report of the DMA, finding that he had provided an explanation of the deficiency in the report of Dr. Hartunian and noted that a copy of the DMA report was attached to the decision. The award ran for 89.28 weeks for the period October 27, 2011 to July 12, 2013.

[8] *Id.* at 516.

On September 1, 2015 appellant, through counsel, requested reconsideration and submitted a March 11, 2014 report from Dr. Hartunian, which reiterated that the only disagreement with the DMA's rating impairment was the GMFH.

In two supplemental reports dated October 10 and November 11, 2015, the DMA reiterated that there was no documentation of a positive Trendelenburg, appellant did not have an antalgic gait, he did not require the use of a single gait aid or external orthotic device for stabilization, and these findings were consistent with appellant's ability to function per Table 16-6's criteria and, as such, his GMFH was 1.

By decision dated November 18, 2015, OWCP denied modification of its prior schedule award decision.

On January 19, 2016 appellant, through counsel, requested reconsideration.

By decision dated March 23, 2016, OWCP denied modification of its prior schedule award decision.

On March 20, 2017 appellant, through counsel, requested reconsideration.

By decision dated May 16, 2017, OWCP denied modification of its prior schedule award decision.

LEGAL PRECEDENT

The schedule award provisions of FECA and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[9] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[10]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[11] In determining impairment for the lower extremities under the sixth edition

[9] 20 C.F.R. § 10.404 (1999); *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[11] A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement (6th ed. 2009).

of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the lower extremity to be rated. With respect to the knee, the relevant portion of the leg for the present case, reference is made to Table 16-3 (Knee Regional Grid) beginning on page 509.[12] After the class of diagnosis (CDX) is determined from the Knee Regional Grid (including identification of a default grade value), the net adjustment formula is applied using the GMFH, GMPE, and GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[13] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[14]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed through a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[15]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[16] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[17] When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical examiner (IME) for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[18]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP accepted that appellant's claim for synovitis/sprain of left knee, medial meniscus tear of the left knee, and post-traumatic arthritis of the left knee and authorized two left knee surgeries which were performed on January 25, 2005 and September 20, 2010.

In support of his claim for a schedule award, appellant submitted an August 23, 2013 report of his attending physician, Dr. Hartunian. Utilizing Table 16-3, *Knee Regional Grid*, of the A.M.A., *Guides*, Dr. Hartunian opined that appellant's condition was consistent with a class 3

[12] *See* A.M.A., *Guides* (6th ed. 2009) 509-11.

[13] *Id.* at 494-531.

[14] *Id.* at 23-28.

[15] *Id. See C.K.*, Docket No. 09-2371 (issued August 18, 2010).

[16] 5 U.S.C. § 8123(a).

[17] 20 C.F.R. § 10.321.

[18] *J.T.*, Docket No. 18-0503 (issued October 16, 2018).

diagnosis for section total knee replacement because the physical examination indicated a mild motion deficit per Table 16-25. He did not assign a GMCS, he assigned a GMPE of 2, and a GMFH of 0 because there was no antalgic limp. Dr. Hartunian had appellant complete an AAOS lower limb questionnaire and found that appellant's answers warranted a grade modifier of 3 for severe deficit. He explained that the A.M.A. *Guides* indicate that the higher grade modifier of 3 was to be used in the net adjustment formula. Using the net adjustment formula, Dr. Hartunian calculated that appellant had a net adjustment of (0-3) + (3-3) + (n/a) = -1, equaling a class 3, grade B impairment. Based on these calculations, he concluded that appellant had 34 percent permanent impairment of the left lower extremity.

In accordance with its procedures, OWCP properly referred the case record to a DMA, Dr. Slutsky, who reviewed the clinical findings of Dr. Hartunian's reports and determined that appellant had 31 percent permanent impairment of the left lower extremity based upon Dr. Hartunian's objective findings. The DMA concurred with the rating of the examining physician, but disagreed with Dr. Hartunian's GMFH of 3. He explained that the AAOS score was unreliable and used only as an "adjuvant," not the main determinate of the GMFH. The DMA further explained that per Table 16-6's criteria, appellant's GMFH was 1 for a mild deficit. He concurred with Dr. Hartunian's GMPE of 2 and that a GMCS was not applicable in this case. Using the net adjustment formula, the DMA calculated that appellant had a net adjustment of (1-3) + (2-3) + (n/a) = -2, equaling a class 3, grade A impairment. Based on these calculations, he concluded that appellant had 31 percent permanent impairment of the left lower extremity.

The DMA's report was provided to Dr. Hartunian who replied by a June 4, 2014 letter providing his rationale for providing a GMFH of 3 per Table 16-6 of the A.M.A., *Guides* based upon his physical examination of appellant and review of his AAOS scoring. Dr. Hartunian further explained that it was his opinion that the DMA had misconstrued the proper use of Table 16-6 and the use of the GMFH.

Dr. Hartunian's June 4, 2014 letter was provided to the DMA who, in two additional reports, continued to disagree over the proper grade modifier under Table 16-6.

The Board finds that, as the reports of Dr. Hartunian and DMA Dr. Slutsky are virtually of equal weight, a conflict of medical opinion exists as to the proper GMFH and the appropriate use of the AAOS lower limb questionnaire. Referral to an IME is therefore required.

On remand OWCP shall refer appellant, along with the case record and a statement of accepted facts, to an appropriate specialist for an impartial evaluation and report which includes a rationalized opinion as to the extent of appellant's left lower extremity permanent impairment. In its referral letter, the independent examining physician shall be asked to provide specific rationale on the GMFH assigned to the left lower extremity along with an explanation as to the appropriate use of the AAOS lower limb questionnaire and Table 16-6, Functional History Adjustment -- Lower Extremities. Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision regarding appellant's schedule award claim.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the May 16, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: September 10, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board